

**DEPARTMENT OF PUBLIC WORKS
DIVISION OF MOTOR VEHICLES**

Medical Review Unit
301 C. Street, N.W.
Room 1033
Washington, D.C. 20001

Permit No:
Applicant's Name:
Date of Birth:
Address:

MEDICAL REPORT

1. BRIEF MEDICAL HISTORY:
2. PERTINENT FINDINGS ON PHYSICAL, MENTAL STATUS OR LABORATORY EXAMINATIONS:
3. KIND OF TREATMENT AND AMOUNT OF MEDICATION BEING TAKEN AT THIS TIME:
4. PROGNOSIS:
5. RECOMMENDATION AS TO PHYSICAL AND MENTAL QUALIFICATIONS TO OPERATE A MOTOR VEHICLE SAFELY:
6. IF THERE IS A HISTORY OF SEIZURES OR LOSS OF CONSCIOUSNESS, THEN RECORD THE DATE OF THE LAST EPISODE:
7. IF THE MEDICAL PROBLEMS INCLUDE A PSYCHIATRIC DIAGNOSIS, THEN COMMENT ON THE CURRENT STATE OF REMISSION:

PHYSICIAN' NAME

PHYSICIAN' SIGNATURE

PHYSICIAN' ADDRESS

TELEPHONE NUMBER

DATE

I, _____ HEREBY AUTHORIZE _____
(patient signature) (care taker of records)

TO RELEASE MY PERTINENT MEDICAL RECORDS TO THE DIVISION OF MOTOR VEHICLES FOR THE PURPOSE OF ASSESSING MY PHYSICAL AND MENTAL QUALIFICATIONS FOR DRIVING A MOTOR VEHICLE SAFELY.